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Worker's Compensation Independent Medical Evaluation History Questionnaire

Instructions

Complete this history questionnaire, to the best of your ability, prior to your appointment. If you do not understand a question, simply leave it blank. We will review this with you at your appointment.

Please return your questionnaire to your attorney to be e-mailed, faxed (515-964-9032), or mailed to our office prior to your appointment, and *bring a copy of your completed questionnaire to your appointment*.

Note that your independent medical evaluation may last **2-3 hours** depending on your situation. Please plan accordingly.

WORKER'S COMPENSATION
INDEPENDENT MEDICAL EVALUATION QUESTIONNAIRE

Your Full Name:_____ Your Age:_____

Are you: ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

Job Analysis

THESE QUESTIONS APPLY TO THE JOB YOU WERE DOING AT THE TIME OF THE INJURY IN QUESTION.

Employer Information:

What company were you working for at the time of the incident in question?

What does this company make/do?

When did you start working there? _____ What shift did you work? _____
Did you work ☐ part-time or ☐ full-time? Are you still working there? ☐ Yes ☐ No
If no, the last date you worked was: _____

Job Title/Tasks:

What was your job title at the time of this injury? _____
Was this job ☐ seasonal or ☐ year round?

Material Handling:

What was the heaviest thing you would lift? _____
How much did it weigh? _____
What was the range of weight in pounds you worked with most of the time? _____

Please estimate how much time you spent working:
Below your waist: _____
Between your waist and shoulder height: _____
Above your shoulder: _____
(**Total should equal 100%)**

Environmental Factors:

How much of your workday was spent working
Indoors: _____% Outdoors: _____%
Hot/Warm environment: _____% Cold/Cool environment: _____%
Did you work outside in all weather? ☐ Yes ☐ No

Exposures: What chemicals could you have been exposed to in the workplace?

Nonmaterial Handling: How much of the workday did you spend doing these activities?

Nonmaterial Handling	**Never**	**Rare** *Less than 5% of the day*	**Occasional** *5-33% of the day*	**Frequent** *34-66% of the day*	**Constant** *More than 2/3 of the day*
Sitting	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Squatting	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Crawling	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Climbing Ladders	☐	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐	☐
Gripping or Grasping	☐	☐	☐	☐	☐
Using Vibratory Tools	☐	☐	☐	☐	☐

Tool Use: What types of tools did you work with? Please include both manual and power tools.

What heavy equipment did you work with? (Such as forklifts or trucks)

What types of personal protective equipment did you work with on a regular basis?

☐ Gloves ☐ Hearing Protection ☐ Hard Hats ☐ Fall Protection
☐ Respirator ☐ Steel toed footwear ☐ Safety Glasses ☐ Other _____

Job Satisfaction: Did you like your job? ☐ Yes ☐ No

Did you have a good relationship your coworkers? ☐ Yes ☐ No

Did you work well with your supervisor? ☒ Yes ☐ No

Concurrent Employment:

Did you have another job for another company at the time of the injury? ☐ Yes ☐ No

If yes, please list.

Employer(s)	Job title	Hours per week worked

History

Please briefly outline in your own words how the injury/illness occurred:

Current Care:

I am not seeing any health care providers now ☐
What physicians or chiropractors, or other health care provider are you seeing **ONLY FOR THIS CONDITION NOW?**

Current Medical Treatment for this injury now:

Medication: _____

Physical Therapy? ☐ Yes ☐ No

Exercise? ☐ Yes ☐ No

Other: _____

Current Symptoms:

Please outline your symptoms below. Try to include whether your pain is constant, the severity, where it is located, etc. We will go through this also during the evaluation.

BACK PAIN PATIENTS ONLY!!

What effect does coughing or sneezing have on your back pain?

☐ Decrease ☐ No Effect ☐ Increase

What effect does bearing down to have a bowel movement have on your back pain?

☐ Decrease ☐ No Effect ☐ Increase

Can you control your bladder functions? ☐ Yes ☐ No

Can you control your bowel movements? ☐ Yes ☐ No

Current Work Activities:

Are you working now? ☐ Yes ☐ No

For the same employer? ☐ Yes ☐ No In the same job? ☐ Yes ☐ No

For a different employer? ☐ Yes ☐ No

If you work for a different employer, what company? _____

When did you start working here? _____

What job are you doing? _____

Current Work Restrictions:

Do you currently have work restrictions assigned by a physician? ☐ Yes ☐ No

If you do, what are the restrictions?

Are they temporary or permanent? ☐ temporary ☐ permanent

Are you able to work within these restrictions? ☐ Yes ☐ No

If you are having problems, please list them.

Aggravating and Relieving factors AT WORK:

What kind of problems do you have at work?

☐ Lifting	☐ Pushing	☐ Pulling	☐ Carrying	☐ Walking
☐ Sitting	☐ Standing	☐ Stooping	☐ Crawling	☐ Kneeling
☐ Working between floor/ waist	☐ Working between waist/ shoulders	☐ Working over shoulders	☐ Working outdoors	☐ Working in hot/cold weather
☐ Using legs	☐ Working on ladder	☐ Going up/ down stairs	☐ Gripping/ grasping	☐ Using hand/ tools/power tools

What do you do to make symptoms better **AT WORK**?

Aggravating and Relieving factors AT HOME:
Please check the following activities that cause you problems, due to your injury, at home.
Please check all that apply.

☐ Travel	☐ Personal Hygiene	☐ Writing	☐ Typing
☐ Standing	☐ Sitting	☐ Reclining	☐ Walking
☐ Going up/down stairs	☐ Lifting	☐ Pushing/pulling	☐ Carrying
☐ Feeling with fingers	☐ Squatting	☐ Grasping/gripping	☐ Intimacy

What do you do to make symptoms better **AT HOME**?

Changes in Symptom Pattern:
When you compare your symptoms now, to:

One year ago:	☐ Better?	☐ About the same?	☐ Worse?
Six months ago:	☐ Better?	☐ About the same?	☐ Worse?
Three months ago:	☐ Better?	☐ About the same?	☐ Worse?

Past Occupational History:
List your past employers, **most recent FIRST.**

Employer	Job	Number of years	Why did you leave?

Past Medical History:
Please list any operations/surgeries you have had in the past.

Please list any **OTHER MEDICAL (NON-SURGICAL)** problems you have or have had in the past:

Prior Worker's Compensation Injuries:

Have you ever had another worker's compensation case in the past? ☐ Yes ☐ No
If yes, please list below.

Year	Injury	Employer	Impairment Assigned

Prior Injuries/Illnesses in the Same Area:

Have you ever had another injury **to the same area** before this injury? ☐ Yes ☐ No

If yes, when and what happened?

Previous Impairment Ratings:

Have you ever had a **previous impairment rating** for the **same** body part? ☐ Yes ☐ No
If yes, what was the rating given, and when?

Intervening Injuries in the Same Area:

Have you had any **new injuries to the same area** since the injury in question? ☐ Yes ☐ No

If yes, when and what happened?

Current Medications:

Prescription Medications:	Non Prescription Medications:

Allergies:

Do you have any allergies to medications? ☐ Yes ☐ No
If yes, list medication(s):

Social History:

Tobacco Use:

Do you smoke? ☐ Yes ☐ No How many packs per day? _____

Total number of years smoked? _____ If you quit smoking, what year did you quit? _____

Other forms of tobacco? ☐ Chewing Tobacco ☐ Cigars ☐ Pipe ☐ Vape

Alcohol Use:

Do you drink alcoholic beverages? ☐ Yes ☐ No

How many alcoholic beverages do you drink per week? _____

What type of alcoholic beverage do you drink? _____

Are you using alcohol for pain management? ☐ Yes ☐ No

Substance Use:

Are you using any substances for pain management? ☐ Yes ☐ No

Family Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How many children do you have? _____

Education:

What was the last grade you completed in school?

☐ Grade School ☐ High School ☐ Some College ☐ College Graduate ☐ Graduate Degree

Do you have your GED? ☐ Yes ☐ No

Military Service:

Have you served in the military? ☐ Yes ☐ No If so, what branch? _____

Were you injured in the military? ☐ Yes ☐ No

If yes, explain:

Do you have a service connected disability? ☐ Yes ☐ No

If yes, explain:

Sleep Patterns:

On average, how many hours per night do you sleep? _____

Do you awaken with a sore throat? ☐ Yes ☐ No Headache? ☐ Yes ☐ No

Do you awaken rested in the morning? ☐ Yes ☐ No

If you have problems getting a good night's sleep, why? _____

_____

Have you ever had or been advised to have a sleep study? ☐ Yes ☐ No

Leisure Time Activities:

What did you do in your free time before this injury/illness?
Please circle the activities you can no longer participate in.

Caffeine Intake:

Caffeine intake per day: cups of coffee _____ soft drinks _____ energy drinks _____
At what time during the day do you stop drinking caffeinated beverages? _____

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